

**A SMARTER WAY TO CARE:  
TRANSFORMING MEDI-CAL FOR THE FUTURE**  
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**California Department of Health Care Services**  
*Little Hoover Commission Hearing*  
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Thank you for this opportunity to present to the Little Hoover Commission our comprehensive report on the Department of Health Care Services (DHCS) and its efforts to improve and expand the Medi-Cal program since 2007.

First, I would like to give a brief overview of Medi-Cal to provide context for the information I will be presenting shortly. Medi-Cal is California's Medicaid health care program. Since its inception in 1966, the program has offered free or low-cost health coverage to low-income individuals who meet eligibility requirements.<sup>1</sup> In California, this generally includes residents who meet income requirements (less than 138% of the federal poverty level, or \$32,500 for a family of four), regardless of whether they have children, disabilities or assets.

Medi-Cal is California's single largest source of health insurance coverage and the country's largest Medicaid program, serving 10.6 million members. Jointly funded by the state and federal government, it supplies a robust array of essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions.

The services and how we deliver them has changed significantly over the years. Medi-Cal has evolved from being a primarily fee-for-service program to one that offers better coordinated, quality care through managed health plans. Now nearly 74 percent of Medi-Cal members are enrolled in managed care plans throughout the state. One of the new programs instituted in recent years is the Coordinated Care Initiative (CCI), which will improve the care provided to adults who need assistance to remain in their homes and out of institutionalized care.

There has been a tremendous amount of change in the healthcare system since the LHC laid out its series of progressive recommendations to improve the Medi-Cal program. In 2007, we served 6.6 million beneficiaries. Under the Affordable Care Act (ACA), Medi-Cal's eligibility was expanded on January 1, 2014, and since then about 2 million individuals have enrolled.

Despite the changes, our focus has remained consistent. At DHCS, our mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use treatment services, and long-term care. Our vision is to preserve and improve the physical and mental health of all Californians.

Our 2013-2017 Strategic Plan is our guide to determine the appropriate strategies that will help us capitalize on upcoming changes to health care delivery, purchasing, and

innovation, while allowing us to maximize our efficiency and our positive impact on the health care system.

The strategic plan defines our strong commitments to our three main constituencies – the people we serve, the public, and our employees.

The commitments in our strategic plan support our dedication to enhancing the consumer experience, improving health outcomes, lowering the cost of care, fostering a positive work environment for DHCS employees, and adhering to our core values of integrity, service, accountability, and innovation.

### **Designate a leader and a strategy team**

In 2007, the LHC recommended that DHCS designate a leader and a strategy team. Chief Deputy Director Karen Johnson is charged with directing the strategy and policy efforts of DHCS, along with the counsel and input from DHCS Executive Staff, our strategy team. Ms. Johnson is responsible for managing and directing the day-to-day operations of the department, implementing the department's policies, and assisting in the formulation of policy to achieve the department's mission.

Dr. Neal Kohatsu was named DHCS Medical Director in 2011, a new position charged with advancing population health and improving clinical quality. His vast experience in prevention, chronic disease management, quality improvement, and patient safety has been particularly valuable as he leads the development and implementation of the department's quality strategy.

Realizing the need for leadership with respect to the collection, processing, and use of Medi-Cal data, DHCS established a new position, the Chief Medical Information Officer (CMIO). Our CMIO, Linette Scott, has a combination of clinical, public health, and informatics expertise and is focused on improving the usability and quality of data in the department to support our programs.

### **Strengthen and Expand Managed Care**

After the LHC's last Medi-Cal hearing in 2007, it was recommended that DHCS strengthen and expand Medi-Cal managed care. We are proud to report on the success of expanding Medi-Cal managed care to all 58 counties. Roughly 74 percent of Medi-Cal's 10.6 million members are enrolled in managed care plans. Through managed care, we are providing better coordination and integration of care with controlled costs. Most of the managed care programs are paid through capitated systems.

This model of care—with an emphasis on primary and preventive care, coordinated delivery of health services, high quality care, and accessibility—is more patient centered, rather than provider centered.

Managed care health plans also offer resources that typically are not part of fee-for-service world, such as nurse advice lines, transportation assistance, help with getting appointments with specialists, health education, and quality improvement programs.

A significant expansion of managed care occurred in the last three years, when nearly 3 million Californians, ranging from children to seniors, transitioned to managed care plans from various DHCS-administered health care programs, such as the Healthy Families Program and the Low Income Health Program. In addition, several hundred thousand individuals enrolled in Medi-Cal when they became eligible under the ACA in 2014.

DHCS and the Department of Managed Health Care (DMHC) both monitor the adequacy of our managed care health plans to ensure access to quality care. DHCS has interagency agreements with DMHC to perform financial audits, medical surveys, and network adequacy reviews for four of our major transitions. DHCS conducts oversight, auditing, and monitoring efforts and conducts readiness reviews of all managed care plans prior to significant population or benefit expansions, such as the expansion of managed care-covered mental health benefits. Because of the significant program enhancements associated with Cal MediConnect, in conjunction with the Centers for Medicare & Medicaid Services (CMS), DHCS completed a readiness review process that encompassed all program requirements in addition to network readiness.

DHCS included significant new requirements in managed care plan contracts to provide health assessments, care coordination, linkages, and transition assistance to seniors and persons with disabilities (SPD) and Cal MediConnect dual eligible members. New requirements include organized coordination between the various delivery systems that provide services to SPDs and Cal MediConnect members, including connections between the managed care plans and the county specialty mental health plans, fee-for-service substance use disorder service system, and long-term services and supports systems.

In 2014, with input from a technical advisory workgroup that included key stakeholders, DHCS released a public Medi-Cal managed care performance dashboard with approximately 20 metrics of health care service quality, enrollment, finance, access, and enrollee satisfaction.

Looking ahead in the managed care arena, challenges include maintaining a robust provider network to care for our expanded Medi-Cal population and ensuring access to quality care. We continue to work with stakeholders, counties, and health plans to improve the managed care enrollment process for members.

### **Mental Health and Substance Use Disorder Services**

A year ago, the Department oversaw the integration of the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP) to DHCS. Since then, our new Mental Health and Substance Use Disorder Services Division (MHSUDS) has focused

on improving how mental health and substance use disorder care is delivered to Medi-Cal members. These services are now among the new “essential health benefits” mandated by the ACA. In many ways, the delivery of mental health and substance use disorder services is new for DHCS, and I’m pleased that DHCS has such strong leadership in this effort.

Our plan to strengthen the delivery of substance use disorder services includes requesting an 1115 demonstration waiver from CMS. If approved, it will allow us to operate the Drug Medi-Cal (DMC) program as an organized delivery system and give state and county officials more authority to select quality providers and ensure access to these vital services.

We are particularly excited about the new Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for substance use disorder and mental health. We are training primary care physicians to use this method to screen youth for early signs of substance abuse or mental illness and start the appropriate treatment protocol. We are currently identifying performance outcomes related to managed care health plan screening for substance use disorder and mental health needs, as well as referrals to Medi-Cal fee-for-service providers and/or county mental health plans.

Stakeholder input is critical to DHCS. We have established a new Behavioral Health Forum that will focus on addressing policy and program issues related to mental health and substance use disorder services. The Behavioral Health Forum includes several committees, including a steering committee, a consumer and family group, and one comprised of county representatives.

### **Medi-Cal succession plan**

The unprecedented strides in the Medi-Cal program over the past several years have been a team effort, led by many qualified individuals. The DHCS Workforce Planning and Development Office (WPDO) coordinates and offers leadership development programs, customized trainings, career counseling, and resources designed to support the upward mobility of all motivated DHCS employees. To ensure that our extensive Medi-Cal transformation efforts outlast personnel and administration changes, WPDO’s staff development efforts have a heavy emphasis on learning and understanding the Medi-Cal program.

### **Value-based purchasing**

Through the Section 1115 Bridge to Reform waiver, California has implemented several payment reforms and value-based purchasing strategies, consistent with the ACA, that have transitioned the Medi-Cal program and safety net system away from fee-for-service and cost-based care toward risk-based payment structures that include incentives for providing high-quality care in the most efficient setting. The state has developed methods of creating incentives for providers to improve process and health outcomes, patient and provider satisfaction, and greater integration and efficiencies.

### **Experiment with new approaches**

DHCS has taken many new approaches to enhance the Medi-Cal program. When the Section 1115 Bridge to Reform waiver was implemented in 2010, it paved the way for several new approaches that improved the Medi-Cal program, especially regarding the services that Californians receive. It provided for:

- Early expansion of Medicaid coverage to 650,000 Californians through the state's Low Income Health Program.
- An expanded the Safety Net Care Pool (SNCP) to provide additional resources to support both safety net hospitals' uncompensated care costs and other critical state programs that are paid for through the SNCP.
- Mandatory enrollment of 360,000 seniors and persons with disabilities into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes.
- Pilot programs to unify care management for children with special health care needs currently served under Medi-Cal and the California Children's Services program.
- Implementation of a series of improvements to public hospital delivery systems to strengthen their infrastructure, prepare them for full implementation of health care reform, and test strategies to slow the rate of growth in health care costs throughout the state.

Here at DHCS, we have committed to our own culture of quality by integrating quality into all activities of the department—administrative, programmatic, and policy. We have already begun the quality journey in significant ways with the recent release of the new [Strategic Plan](#), updated [Quality Strategy](#), and the launch of the Kaizen Group, a team that is leading several innovative, quality improvement projects. One of these projects will ensure that callers to DHCS are rapidly and directly referred to the appropriate division to address their questions. We are striving to eliminate the serial, call-transfer phenomenon that invariably produces frustration and even anger among members.

We are developing and expanding training opportunities in quality improvement methods through the CMS Adult Medicaid Quality Grant and our interagency agreement with the U.C. Davis Institute for Population Health Improvement. Through these resources, we have launched two clinical quality initiatives, one to improve maternal outcomes and the other to enhance diabetes care. We are also providing quality improvement learning opportunities through the Journal Club, Learning Series, and a Culture of Quality Book Club under development. We have implemented a new method—the diagnosis related group—of paying for hospital inpatient services in the fee-for-service Medicaid program. The new method will apply to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals.

DHCS has begun a new stage of work to assess and plan for implementation of an ACA Section 2703 health homes program(s). California enacted AB 361 in 2013, which

authorized DHCS to implement an Enhanced Medical Homes health home program if DHCS determines that such a program would be operationally viable, produce positive health outcomes, and be at least cost neutral. Stakeholder engagement, to be followed by State Plan Amendment (SPA) development and application, will begin in the summer of 2014. DHCS is also coordinating with the Health and Human Services Agency California State Innovations Model (CalSIM) Planning and Testing Grant process, which includes a multi-payer health home proposal.

### **Create incentives to improve outcomes**

People naturally respond to incentives to change behaviors. DHCS has capitalized on this in its efforts to improve the health of Californians. One program, the Medi-Cal Incentives to Quit Smoking (MIQS) Project, motivates Medi-Cal members to quit smoking by offering a \$20 gift card to members who call the California Smokers' Helpline and enroll in its free telephone-based support services.

The passage of AB 915 in 2007 allowed DHCS to develop policy guidelines for non-monetary member incentives used by Medi-Cal managed care plans. The [guidelines](#) were issued in March 2009. DHCS requires plans to submit evaluations at the end of each member incentive program and annual updates for ongoing programs.

Another incentive program, the performance-based Auto Assignment Incentive Program implemented in 2005, was refined in 2013 to offer plans an even greater incentive for good performance. Based upon an assessment of eight performance measures related to the quality, access, and timeliness of care, the program rewards better performing plans with more assigned mandatory enrollees (those who do not choose a plan). DHCS convenes a stakeholder workgroup every year to review prior year results and recommend changes or additions to the performance measures.

### **Encourage emergency room alternatives**

With the ACA and Medicaid expansion, millions of Californians are gaining health coverage, many for the first time, and are able to select a provider to visit for regular health care visits. When an individual knows they have a primary care provider, they are more likely to visit the provider than the emergency room in non-emergency situations. All managed care members have an assigned primary care provider medical home and assistance from the plan to ensure access.

### **Medical homes**

DHCS seeks to improve the quality and efficiency of care provided to fee-for-service Medi-Cal members with disabilities and chronic illnesses through a statewide infrastructure of Enhanced Medical Homes (EMH). In this context, the EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services.

The EMH program provides a medical home for each eligible member and establishes a mandatory relationship with a patient-centered primary care provider who will address the member's psychosocial, preventive care, and social support needs and manage interventions and linkages to community-based services

### **Encourage patient responsibility**

One way that DHCS encourages personal responsibility for Medi-Cal members is in the area of long-term care services. The California Partnership for Long-Term Care is dedicated to educating Californians about the need to plan ahead for their future long-term care and to consider private insurance as a vehicle to fund that care. The partnership collaborates with a select number of private insurance companies that have agreed to offer high quality policies that meet stringent requirements set by the Partnership and the state of California. In addition to many other consumer protection features, Partnership policies offer the special benefit of Medi-Cal asset protection.

In addition, Medi-Cal managed care provides members with the tools needed to select their health plan and providers. They are also able to participate in health education classes to learn about health conditions and take action to change their health and exercise habits and improve their health.

### **Develop a data plan**

As discussed above, DHCS is committed to improving and expanding managed care for our members, and we believe that collecting and using data from managed care plans will help us to do this. Data received from managed care plans historically has had a number of quality issues that make it challenging to use for program evaluation and data analytics. With guidance from the CMIO, the department is transforming the data quality in partnership with our managed care plans to improve completeness, timeliness, reasonableness, and accuracy. Additionally, DHCS has made system improvements that will support the use of national standards for data from our managed care plans that will improve both quality and efficiency of the data. These process and system improvements will support DHCS in monitoring the programs and plan performance as well as reporting to the public and our stakeholders.

DHCS is also committed to increasing data analytic capacity within the department. With leadership from the CMIO and support through the Adult Medicaid Quality Grant and our partners, DHCS has increased the training opportunities for staff with respect to the use of performance measures and data analytics. DHCS has developed monitoring dashboards for managed care and Cal MediConnect to measure program successes and challenges. The dashboards also include vital health data of members.

In addition, we are developing an enterprise data strategy as part of our work to improve our Medicaid Information Technology Architecture (MITA) maturity. MITA is a CMS initiative and framework that supports states as we streamline our processes and improve efficiencies. There are opportunities for enhanced federal funding to support

improvements that are consistent with the MITA goals, and DHCS is leveraging that in developing our enterprise data strategy, data models, and data standards.

Using a variety of data sources and research, DHCS created “Health Disparities in the Medi-Cal Population” fact sheets to provide a snapshot of the health of Medi-Cal members from various backgrounds, compared to the state population, so that health organizations, government officials, policymakers, and advocates can better understand possible health disparities.

### **Track quality and fight fraud**

DHCS is committed to being prudent, responsible fiscal stewards of public resources. Staff conduct data analysis and research related to member demographics, enrollment trends, utilization of services by plan members, and the quality of care provided to members.

In September 2011, DHCS partnered with both public and private groups to raise awareness of health care fraud and provide steps to reduce patient and provider risk. Together with CMS, the California Medical Association, the California State Attorney General, the Office of Inspector General, and the Senior Medicare Patrol, a series of 23 presentations were made throughout California. All Powerpoint presentations are posted on the DHCS website.

Audits and Investigations (A&I) are using new auditing and investigative procedures to monitor the practices and billing activity of providers. They work to ensure quality care is provided, reduce the occurrence of fraud, uncover instances of provider and beneficiary identity theft, and make referrals for criminal investigation and prosecution. Provider enrollment procedures used by the Provider Enrollment Division (PED) include more extensive application packages, provider background checks, and onsite reviews, as well as moratoriums on enrollment of certain high-risk provider types.

In January 2014, DHCS developed an implementation plan to address each of the recommendations in the November 2013 Drug Medi-Cal limited scope review.

### **Leverage outside research assets**

DHCS continues to work with outside research partners through interagency agreements that have supported a variety of projects. U.C. systems have provided program evaluation for transitions, such as the Low Income Health Program, as well as analytic and training support, such as the contract with the U.C. Davis Institute for Population Health Improvement for quality improvement and analytic efforts. Additionally, DHCS is partnering with the U.C.s to support the Adult Medicaid Quality Grant work and survey analysis.

DHCS continues to work with researchers through the Data and Research Committee, which provides opportunities for researchers and public health to request Medi-Cal data

for analysis. This is supported by DHCS staff and our primary data warehouse, the Management Information System/Decision Support System (MIS/DSS). The MIS/DSS is a data warehouse created by DHCS that manages and stores a vast amount of data (10 years of data, or about 2.5 billion records) that are extracted from approximately 30 different sources, allowing DHCS analytical staff to query specific types of claims or encounters and create analytical reports.

### **Replace claims payment information system**

CA-MMIS was redesigned in 2012 to enhance claims processing and to support providers as they convert to Electronic Health Records.

SB 853 in 2010 required the California State Auditor to monitor the transfer of operational responsibility for CA-MMIS to Xerox and the subsequent design, development, and implementation of a replacement system, which is called Health Enterprise. The final implementation date of the new software development approach is no later than December 2016.

DHCS, our oversight agencies, and our stakeholders continue to monitor Xerox's progress carefully and are taking all appropriate and necessary actions to hold Xerox accountable for delivering a quality and timely Health Enterprise system.

### **Integrate electronic patient information**

Since the LHC's report, the passage of the federal Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 has provided resources to California that have transformed the health care delivery system. DHCS chose to implement the Medi-Cal Electronic Health Record (EHR) Incentive Program in partnership with CMS to provide direct incentives to eligible hospitals and eligible professionals for adoption EHRs and using them meaningfully. The program has also provided support in partnership with associations to assist providers with this task.

To date, California Medi-Cal providers and hospitals have received more than \$630 million in total payments. DHCS is committed to the continued support of this program through 2021 and has identified the goal of supporting increased use of health information technology in our Strategic Plan.

### **Align application, eligibility, and renewal procedures with federal rules**

The Medi-Cal enrollment process has changed markedly since the LHC reviewed it in 2007. The process has been streamlined and may be done in person, mail, online, or by phone. The new online system for applying for health coverage, California Healthcare Eligibility, Enrollment, and Retention System, or CalHEERS, launched on October 1, 2013, and offers a "one-stop shop" for applying. It is jointly administered by DHCS and Covered California (California Health Benefit Exchange). CalHEERS is the portal and "no wrong door" approach that enables Californians to determine their eligibility for subsidized health benefits, compare insurance plan options, and enroll in

low-cost or no-cost health coverage programs, and it offers immediate eligibility status. It also allows consumers to make online changes in eligibility. Additionally, the no wrong door is related to many portals (e.g., in person, online, phone, mail, etc.), not just CalHEERS.

The assets test no longer applies for most applicants. As of January 1, 2014, the county online applications for health-only benefits should include questions related only to income and deductions. There is no asset test under the new eligibility rules of the ACA for most applicants. However, applicants who are blind, disabled, or over age 64 who seek Medi-Cal membership are evaluated under the pre-ACA rules as required by the federal government.

### **Encourage innovations in renewal procedures**

Starting this year, the Medi-Cal annual redetermination will be conducted via an “ex parte” review of available information to determine eligibility for renewal. An “ex parte” review refers to an upfront review of current beneficiary data and information before asking the beneficiary for additional data. This may result in an up-front renewal of Medi-Cal benefits without a beneficiary having to complete an annual redetermination packet.

The ACA changed the way Medi-Cal eligibility is conducted for most individuals. The biggest change is the implementation of the MAGI income methodology, which relies on tax household rules to determine income and household composition. In order to make eligibility determinations for continued Medi-Cal coverage, Medi-Cal must collect individuals’ information based upon the MAGI rules.

DHCS has numerous options for members who may need help. Members can provide the information via phone or in person. They can correspond with DHCS and submit the information by email. Additionally, county eligibility workers reach out to each member who does not provide the required information before they are disenrolled.

DHCS believes strongly in its policies to assist individuals in completing the annual redetermination process. Individuals no longer are required to provide paper verifications, and individuals are no longer required to complete and return a form (they can call and submit the information by phone, for example). County eligibility workers will also be reaching out to collect the required information through various means, including using any existing information in the member’s case record to complete the renewal.

### **Conclusion**

In closing, I want to express our appreciation for the LHC’s interest in Medi-Cal and making sure that Californians who are eligible for health care coverage through Medi-Cal are able to access quality care and comprehensive services.

As public servants at DHCS, we're fortunate to be able to see the real impact of our work for such an important, dynamic department. What we do each day makes a tremendous difference to millions of people in need. Through our dedication and excellence, we are realizing our vision of improving the physical and mental health of all Californians. Each and every year at DHCS, we look back on the previous year and feel satisfaction and pride at the many accomplishments we reached. It makes us proud to be a part of this wonderful team.

As you have heard from this overview, we at DHCS have taken to heart and implemented the recommendations that the LHC provided in 2007 for improving the Medi-Cal program. We have made great strides, but there is more work to be done. We look forward to any further feedback the LHC may have to help us in our commitment to protect the health and well-being of the people of California.

Our work is as important as anything happening in California government today, and we're eager to continue improving how we serve the residents of our state. Thank you for this opportunity.

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## i Do you qualify for Medi-Cal benefits?

To see if you qualify based on income, look at the chart below. Income numbers are based on your annual, or yearly, earnings.

<i>Family Size</i>	<i>138% of Federal Poverty Level</i>
<i>1</i>	\$16,105
<i>2</i>	\$21,708
<i>3</i>	\$27,311
<i>4</i>	\$32,913
<i>5</i>	\$38,516
<i>6</i>	\$44,119
<i>7</i>	\$49,722
<i>8</i>	\$55,325
<i>9</i>	\$60,927
<i>10</i>	\$66,530
<i>11</i>	\$72,133
<i>12</i>	\$77,736
<i>Each Additional Person</i>	<i>Add \$5,603</i>

You can also get Medi-Cal if you are:

- 65 or older
- Blind
- Disabled
- Under 21
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative or a child under 21 if:

The child's parent is deceased or doesn't live with the child, or

The child's parent is incapacitated, or

The child's parent is under employed or unemployed